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TABLE OF CONTENTS

EDITORIAL COMMENT

This issue of the *Bulletin* presents two papers on a type of school attendance problem and the discussion of these papers which were given at a session of the National Association of School Social Workers held during the 1948 National Conference of Social Work. The papers review psychiatric study of what one group has called school phobia and of truancy cases as they were referred over a period of years in New York City public schools.

These papers should be thought of as the experience of highly specialized psychiatric resources used by the schools in this city. Reports such as these offer much to stimulate understanding of children and their parents and point again to the importance of the well-adjusted school person's ability to relate to children. In this day of teacher shortages, consideration of the teacher's personal needs as well as her professional assets must be kept always in mind so that the schools do not hire primarily certified people to fill vacancies, but instead ask whether the teacher is a person who can live and work effectively with children.

The role of the school social worker in working directly with the child, parent and teacher, as well as in manipulating the school environment is briefly discussed in both papers. It is hoped that these aspects of school social work practice can be amplified in forthcoming issues of the *Bulletin*.

Miss Green's discussion of the two papers has within it a real challenge for members of the Association. Her material clearly sets up for us the need for study, and for continuous development of skill in case work practice in aspects briefly discussed in the papers.

CHILDREN'S FEARS IN RELATION TO SCHOOL ATTENDANCE*

By JEAN A. THOMPSON, M. D., *Bureau of Child Guidance*

Board of Education, New York City

INTRODUCTION: I shall discuss those children who have what we have come to call school phobia, a symptom of an anxiety neurosis, seen more often in elementary school children and characterized by refusal to attend school because of tremendous fear of some dire calamity.

OCCURRENCE: Within the past two years there has been a great increase in the number of such cases that have been referred to the Bureau of Child Guidance from certain areas in New York City, notably those areas where there is little economic deprivation and where the families are of good cultural background. From one such area in Brooklyn about 13 cases of school phobia were referred to the Bureau in the ten years from 1936 to 1946, and from this same area 19 cases were referred in the one year, 1946-47.

It is interesting that in the Harlem area in New York where there are poor social conditions and marked deprivation, very few cases of school phobia have come to the Bureau's attention.

MATERIAL STUDIED: For the purposes of this study, thirty-two cases have been selected, 15 boys and 17 girls, ranging in age from 5 to 16. The majority of the cases, 24, were in the age range from 5 to 10 years inclusive. 8 cases were between 11 and 16 inclusive. Thus they were in school grades all the way from kindergarten to junior high school. Except for one child, they were not seriously retarded in grade placement, perhaps because of the trend toward 100% promotion in the schools.

SYMPTOMS: The presenting symptom is usually refusal to attend school. In a few cases the child at time of referral was still in school, but was exhibiting extreme panic, either crying and screaming for mother and wringing hands or getting as far as principal's office and refusing to go to the classroom. In some cases of developing school phobia, the child was habitually late due to the difficulty in leaving home in the morning.

With most of the children who were old enough to describe their symptoms we found the usual physical manifestations of anxiety, nausea and dizziness and sometimes vomiting occurring on school days,

*Delivered at National Conference of Social Work, Atlantic City, April 20, 1948

but not at other times. On a few occasions when we observed the child's panic in our office it was noted that the child blanched with a sickly pallor. This obvious physical symptom may be one reason why the schools, on the whole, have dealt sympathetically with these cases. In several cases there were other physical complaints for which no organic basis could be found—pain in the stomach, diarrhea, headache, a choking sensation.

In several cases the families had made efforts in 2 or 3 successive school terms to get the children to school. Fourteen of the children had a paralysing fear of losing the mother or of losing both parents. This fear was manifest in their clinging to the mother, refusing to let her go out without them or in keeping close track of her, coming in at intervals from play to see that mother was still there. There was in this element of domination which both parent and child often recognized.

In 11 of the cases there were nightmares, fear of the dark, or sleep disturbances. Eight of the children were fussy about food or refused to eat. Twelve children had difficulty in getting on with other children and some of these had no friends. In a number of cases there was close association only with relatives both on the part of the family and on the part of the child.

FAMILY'S ATTITUDE: The handling of the school phobia by the family and occasionally by the school served to increase the child's fear and to prolong the period of non-attendance. In practically every case there was extreme anxiety on the part of either or both parents. They spanked, nagged, threatened to leave the home, or threatened to send the child away. In some cases the child was dragged to school. Sometimes this punitive treatment alternated with bribery and indulgence. In 21 cases there had been some obvious psychic trauma or precipitating incident either in the past or immediately preceding the refusal to attend school. In some cases it was a move to a new neighborhood—in others, a transfer to a new school or a new teacher. In some of the younger children the precipitating incident was a failure to meet the mother when the child came out of kindergarten. In other cases it was an episode which the child construed as a hostile attack, a scolding by the teacher or an attack by another child.

BIRTH AND DEVELOPMENTAL HISTORY: The birth and developmental history of this group showed the usual variations. In line with our knowledge of the narcissism among the mothers it is interesting that 19 of the 32 children were not breastfed at all, or, for only a few weeks. Only 9 of the children had a history of enuresis.

PHYSICAL FINDINGS: A large proportion had visual defects corrected in only a few cases by glasses. Many had carious teeth which might be expected as many of them were afraid to go to the dentist.

INTELLIGENCE: Twenty-three of the children had average to superior intelligence. The rest were in the dull range. One boy, because of anxiety, could not cooperate fully on the tests, but he appeared to be functioning on a defective level. We understand that school phobia is occasionally seen in defective children.

ACHIEVEMENT: In all but 2 of the children there was retardation in achievement in reading, arithmetic or both. Three boys had reading disabilities. Two of the girls were above grade in achievement.

HOME ENVIRONMENT: Only 6 of the 32 were only children. Sixteen had older siblings and 10 were the youngest of the living children in their families. All but 3 of the children were living with both parents. The fathers of the 3 were dead and the children were living with their mothers. In several cases there was a grandparent or an elderly aunt living in the home and complicating matters by their nagging punitive efforts to control, or, in one case, terrifying the child with the symptoms of a psychosis. There was no case in which the father had been away in the last war. In all but 5 cases the families lived in comfortable economic circumstances.

PERSONALITIES OF PARENTS: It was in the personalities of the parents that we found the most constant factor influencing the development of the school phobia. In nearly all the cases the mother was an over-anxious, over-solicitous person. In most cases she was a compulsive type who domineered her home. These mothers were, on the whole, immature, narcissistic women, consciously or unconsciously rejecting of the idea of children. They sought from their children some satisfaction of their own narcissistic needs and were hurt and angry when the child could not accept the burden. Thus, as the mother was frustrated by the very immaturity of the child, his inability to conform rigidly to her rules and her expectations, she became punitive, then guilty and anxious lest her negative feelings might really bring disaster. She sought often to compensate by over-solicitous care. Frequently she continued to dress the child or to feed him far beyond the usual age for these attentions. Often the mother centered her anxiety on the child's health, took him to doctors a great deal. These mothers, with their compulsive ideas about cleanliness, were fussy and punitive if the child dirtied his hands or his clothes, or was untidy in the house. Often the child had had no opportunity to learn to play with other children

as the mother had over-protected him, fearing contagion or showing undue concern over children's quarrels. The mothers who were widows tended to bind the children to them with a kind of dependency and yet thrust them off with unmistakable rejection.

Charles illustrates this. He was a boy of 10 years, 4 months old and in the 4th grade, an only child living with his mother. Father had died when Charles was 3. Mother had taken him to school every day until this year and when she suggested in the Fall that he go with a friend he was frightened and nauseated. So for the first 6 weeks mother took him to school as often as she could get him there, which amounted to about 10 half-days. He cried and said he was sick and could not go most of the time.

Charles had been completely infantilized by his mother. She helped him bathe and dress, fearing he might slip and get hurt in the bathtub. She worried about his health and kept him out of school much. She took him to many doctors in spite of her very low income. They slept together.

Mother had had a very deprived childhood. She had felt her sister was favored and had resented her father's refusal to allow her to get an education. In spite of the mother's over-solicitous care of Charles, the social worker's impression was that she resented the responsibility.

Physical examination showed Charles to be overweight. He had a visual defect, only partially corrected by glasses. He had had an appendectomy. He was too emotionally disturbed to cooperate on psychological tests, but the Rorschach test indicated at least average intelligence and he was reading at a 4th grade level.

He came willingly to the psychiatrist's office without his mother and was well able to verbalize his difficulties. He told of his mother's punitive treatment and of her threats that the truant officer or the police would come if he did not go to school. He felt mother was unreasonable to punish him when he really wanted to go to school, but couldn't. With clay figures he expressed great hostility against both parents and against the teacher and the principal. His guilt about this, however, made him expect death from these sources. His bewilderment about his mother's inconsistent treatment was apparent in his fantasy with clay figures. He said concerning the mother figure "She kills the child. She's a bad mother. She doesn't like the child. She likes only bad children. She doesn't like children that are good."

At times he openly attacked his mother with hostile aggression. Mealtime was a source of extreme conflict between them. Because of his

guilt about his hostility, Charles frequently played that the punishing child got killed and he talked of killing himself. Once, in his mother's presence, he pointed a knife at himself. He was sure he deserved punishment, feared the school principal did not like him and reasoned, "If people don't like you, they may call the police; the police may put you in jail; if you are in jail you may go to the electric chair." Masturbation added to his guilt and his confusion was evident in his fantasy that he was really his mother's husband. He said that thinking made him so.

After 5 months of treatment Charles went back to school at first in the afternoon only with his mother sitting in the classroom. For a time he continued to retaliate against the mother by remaining in bed in the morning.

In contrast to the mothers, the fathers in our cases have, with few exceptions, been gentle, kindly men who accepted the domination of their wives. In four cases, however, the anxious, domineering personality which we have described as characteristic of the mothers was seen in the fathers. In these cases the mother was under strain to live up to the father's standards in the care of the children.

In a few of the homes there was real cause for anxiety in the health of one of the parents or in poverty. In 8 cases there was open friction between the parents with separation imminent in 2 cases.

PSYCHIATRIC FINDINGS: The children differed from each other in the amount of repression of feeling which they showed. A few were constricted personalities with apparently little fantasy life. In these, however, the Rorschach test showed deeply repressed anxiety as well as hostility. Others were quite open and able to verbalize their feelings.

These children were all very uncertain of their parents' love and both in the Rorschach test and in psychiatric interview they revealed great hostility toward mother or father or both. There were death wishes against the parent. There was a great deal of hostile fantasy often consciously fed by radio stories and movies from which they gained a vicarious satisfaction, but which also aroused guilt and fear. In many, the unsolved Oedipus complex was obvious and the Rorschach test showed some sexual conflict in practically all of the cases. The envy of the mother was very strong in some of the girls and these girls appeared to be miniatures of their mothers. They were dignified, maturely polite in their behavior and one who was only 8, but showed some physical signs of early puberty, was quite seductive in manner.

As a concomitant of the hostile wishes against the parent there was tremendous guilt and fear of punishment. There was fear that the mother would die or that the child himself would be killed (even by an angry teacher) or that the parents would separate and the child might thus lose both parents. The child's feeling that he needed punishment was apparent in those cases who spoke of killing themselves, and it accounts for the fear of dire calamity in all cases. Sibling rivalry was strong and the real or fancied favoritism of the sibling was one more point against the parents and another source of guilt for the child.

In line with this, there was an inability to tolerate the competition with other children in school. Failure in school involved humiliation before other children, perhaps a scolding from the teacher. One child said "Maybe people won't like me because I'm dumb. If people don't like you they may hurt you, may kill you." Beyond this fancied hate in school was also the feeling that failure meant loss of mother's love. "If mother doesn't love me, she may go off and leave me," reasons the child. In many cases mother threatened to do this. One boy, who had a reading disability which made it impossible for him to come up to class standards, lived in constant fear that any misstep on his part, failure in school, chasing a cat into the street so that it was in danger of being run over, anything which displeased his mother might send her to the hospital. Her commonest threat was, "You go to school or I'll have to go to the hospital." In their group of people you went to the hospital only when you were about to die, so this constituted a threat of death, permanent loss of the mother. This boy said he could much better have stood a beating than this threat.

Anything that added to their guilt added to their fear. Thus one boy was distressed about some sex play to which he had been introduced; a 7-year-old girl was sure that because she bit her fingernails the doctor would have to operate on her. Being orthodox in her religious views, she worried lest by masturbation she mix the meat and the dairy products up inside of her and for this sin she might be punished. Hence, when the school nurse appeared in her classroom and said she wanted to see a few children, even though Joan's name was not mentioned, the child began to vomit and then could not return to school.

DIAGNOSIS: Diagnosis in practically all of our cases was psychoneurosis, anxiety type, although in some of the younger children we called it Primary Behavior Disorder, Neurotic Disorder, Anxiety. Only one child showed signs similar to those of early schizophrenia, but cooperation on the part of the boy and his family was poor and we

could not be sure of the diagnosis.

TREATMENT DURATION: It is difficult to discuss the duration of treatment as the number of interviews per week as well as the total number of interviews was influenced by the crowding of the clinic schedule. For the most part the children returned to school after a treatment period, varying in length from 3 weeks to 7 months. There were 6 cases where response was poor or where the family could not bring the child to the clinic or where there was a stubborn holding on to the symptoms. In these cases we recommended and obtained permission for the child to be exempted from school and given home instruction. Occasionally the school phobia recurred when school attendance was interrupted by an illness or by a vacation period.

TREATMENT METHODS: Treatment methods differed according to the age of the child and his ability to respond, but all treatment aimed first at release of hostility. Sometimes little more was needed, as in the case of William, a boy of 6 years and 2 months, whose family had tried in two successive years to get him into kindergarten. He was the older of 2 children living with both parents. The younger was a girl, 2½ years old, much more secure and self-sufficient than William, the favorite of the father and the relatives. William had a marked strabismus and high myopia for which he wore glasses. He refused to go with the psychologist for his test and when seen by the psychiatrist in the waiting room he was clinging to his mother and crying bitterly. In order to allay his fear of aggression in others the psychiatrist gave her attention to William's umbrella which had a novel handle. He soon stopped crying and began to participate in hitting some toy soldiers with clay balls, a game which the psychiatrist initiated and into which two somewhat older boys were invited to join. William enjoyed this and agreed to return the next day. He was seen each day for a while and came to the psychiatrist's office, but insisted that his mother remain in the room. At the third visit, however, he began to allow her to leave for short intervals.

At the fifth visit the psychologist was introduced and she was able to get his cooperation. The examination was given in the psychiatrist's office and with the mother present, as it seemed best not to take William into unfamiliar surroundings. Under these conditions he obtained an I. Q. of 83 which was considered minimal.

His mother was most unobtrusive and, in fact, did not appear to have the anxiety so often seen in the mothers of children with school phobia. She seemed warm and understanding. We did note, however,

a strong educational drive and both she and father had spanked William for his failure to go to school. Mother had also threatened to go away or to send William away. She was aware of the effect of this treatment, however, and appeared ashamed of it.

At William's eighth visit to the psychiatrist he allowed the mother to leave after a few minutes and was not concerned about her return. On this occasion he began to show some hostility and negativism toward the psychiatrist. This continued until the psychiatrist suggested he draw a gun. He drew a gun, shooting a little girl. He then revealed that he got mad at his sister and when scolded by mother he felt that sister was loved more. He was willing to go to school if mother could remain with him as he feared the teacher might kill him. With clay figures he made the child destroy the punitive parents, but the child was, in turn, destroyed by the father. The psychiatrist assured William that even though mother got angry sometimes she seemed to love him. William agreed that it appeared that way in our office, but added "At home she's a son-of-a-gun."

About ten days later William was ready to go into school. The social worker arranged that he be admitted to kindergarten as this seemed the better program to begin with and we felt his poor eyesight put him at a disadvantage. It was arranged also that mother sit in the classroom. As she had done, in the psychiatrist's office, she absented herself for gradually increasing intervals each day, always telling William when she was leaving. By the end of a week he was able to go to the classroom without his mother.

In this case the social worker had comparatively few interviews with the mother as she had had to remain with William. Mother readily accepted the suggestion that the family stop all pressure for school attendance. She was able to see reasons why William might be jealous of his sister and she tried to counteract the preferential treatment of sister by father and relatives. She also gained a better understanding of the role that William's eye condition might play in his feeling of insecurity in school and she became more patient with his behavior.

With some of the younger children merely a relationship with one or more members of the Bureau Staff was sufficient to build confidence in people and enable the child to return to school. Play therapy was used with younger children and psychotherapy with those who were older and more able to verbalize. In a few of the repressed, constricted personalities, drawings and stories that the child made up revealed enough of the inner fantasy life to enable the psychiatrist to know what

was there and to give some interpretation.

Such a child was Marion, 8 years and 10 months old, and in the 3rd grade. She was referred to the Bureau by the school because she refused to attend. She was the older of two children living with their parents. The younger sibling was a girl 6 months old. Family's economic level was a little above average. Marion slept in the room with her parents.

The younger sister was born in the spring and the mother had to return to the hospital twice, a circumstance which was very disturbing to Marion. Mother was irritable and depressed for a few months following this and talked of dying. In September, at the opening of school, Marion began to cling to her mother. She would not allow the mother to go anywhere without her. Mother took her to school and promised to remain in the Principal's office, but went home. Marion went to look for her and finding her gone, had a temper tantrum. The next day Marion refused to go to school. She was scolded and spanked by both parents. From then on, she could not leave her mother at all The parents ceased their punishments as they did no good.

Both parents were American-born. There was nothing unusual in the father's background. He seemed a well-adjusted person who had a great deal of insight into Marion's personality. He revealed that she was very jealous of both the baby and her mother, a situation of which mother was not aware.

Mother was next to the youngest of four children. She felt great rivalry with her siblings and carried this rivalry into her adult relationships. She always had to be the best-dressed woman in her group, she wanted to have perfect children. In the course of treatment, she became aware of her compulsive drives for cleanliness, her fear of germs, her need to associate with the right people. She realized that Marion's failure was construed by her as her own failure and she never dared tell her own mother about Marion's being out of school. The maternal grandmother was very domineering and the mother recognized her need to control Marion as an attempt to fulfill her wish to control the maternal grandmother.

Physical examination was negative. On a Stanford-Binet Marion scored an I. Q. of 118 and she was one year above grade in achievement in reading and arithmetic.

For the first four interviews with the psychiatrist Marion insisted that her mother remain in the room. As she became more secure, she was able to sit outside the closed door of the social worker's office where mother was and then came alone into the psychiatrist's office.

Marion did no spontaneous talking, answered questions in monosyllables and spoke in a half-whisper. With some stimulation from the psychiatrist she was able to make up stories about a family. She wove into these stories experiences analogous to her own. The little girl in the story quarrels with her mother about eating and is punished by having to eat cereal and milk. The sibling rivalry became clear, the mother's irritability, unfairness and punitive treatment. The father appears as kindly, rescuing the little girl from danger. He takes the little girl with him and mother is left out. Marion said the little girl feared to go to school because she thought the teacher would shoot her if she did not do the examples right. On another occasion the child feared the school would burn down and she would be killed.

The child's fear of the mother was evident. In the stories the little girl got to the point of hitting the mother, but she immediately became fearful that the mother would go away and leave her so she had to hide her feelings.

In the course of treatment Marion began to talk in a normal voice; she skipped happily to the psychiatrist's office ahead of her mother. She revealed her own feelings against her mother. They no longer had to be disguised by the stories. She received reassurance that all children got angry. She was aware that her refusal to eat was a retaliation against her mother and she was able to see that her refusal to attend school punished both the mother and Marion herself.

The following September Marion went into school. At first the mother sat in the classroom, but gradually the child was able to let her leave the room for short periods and then allowed her to stay at home.

During psychiatric treatment it is important that both psychiatrist and social worker avoid any semblance of pressure. With the mother the social worker is satisfied at first to handle the daily complaints about the child's negativism on a purely suggestion level. It is necessary at the beginning to get the family to ease the pressure on the child. Then the social worker can begin to meet some of the parent's personality needs. Many of these mothers come in with a feeling of failure, fear of the husband's or relatives' criticism, guilt about their rejection of their children. The social worker gives the mother complete acceptance. Several of the mothers found themselves for the first time in an atmosphere without criticism. As the mother became more secure she began to give some of her own early history and, with the help of the worker, came to understand her relationship to the child. In some cases the child is an extension of self, there to fulfill mother's ambitions; in other

cases, the child is identified with a hated grandparent; and in still others, he fills an erotic need on the part of an unhappy mother or father. As the mother could face some of her own dissatisfactions, she was able to see the child's need for love and to accept some of his conduct as normal for his age.

The social worker had an important task with the school. It was necessary in each case to prepare the school for the child's return. Permission often had to be obtained for the mother to sit in the classroom. In some cases the cooperation of one of the school administrators was obtained in allowing the child to do some work in the school, like helping to sort books, running errands. With older children, this was an easy introduction to school and gave them some status. There was need in each case to explain the child's insecurity and consequent fear to the school and to see to it that a gentle teacher be found. Then a close contact was maintained with the teacher so as to help her deal with any anxiety that might arise.

In the psychiatric treatment of the child we have found that when the child is able to see his refusal to attend school as a punishment of the parent as well as a punishment of himself, he is about ready to return to school. Frequently, as he returns to school, he begins to feel hostile toward the psychiatrist apparently as the person who takes from him the neurotic crutch on which he leaned. This disappears, however, with some interpretation and a broadening of his interests and the outlets he finds in school work and in friendships.

PROGNOSIS: The prognosis in school phobia cases is good on the whole. Of the 32 cases, 26 returned to school; 2 are still under treatment. Of the 4 who have not returned to school, 3 could not get to the Bureau for continued treatment and one reached the age of employment and obtained working papers. We have seen the school phobia recur in 3 cases, in one after 2 years of continuous school attendance; in the second after 4 years; and in the third, after 7 years. In all 3 of these cases there was difficulty with school work, 2 of the children being intellectually somewhat limited and the third having a reading disability. In 2 of these recurrent cases, the mothers were extremely neurotic, unable to profit from treatment by the social worker and unable to accept their need for deeper therapy.

SUMMARY AND CONCLUSIONS: In this study of 32 cases of school phobia, it was noted that the illness is a psychoneurosis, anxiety, occurring equally in boys and in girls, mostly of elementary school age

and characterized by a refusal to attend school because of a deep sense of foreboding.

This particular combination of symptoms seems to occur in areas of good economic and cultural background where the children are over-protected and kept dependent.

The personality of the mother usually, but occasionally of the father, is an outgrowth frequently of early deprivation and the mother is narcissistic, somewhat rejecting, guilty and over-anxious.

The child reveals hostility toward the parent, guilt and a fear that some severe punishment,usually death of the mother or of the child himself will occur.

On the whole, they respond well to treatment aimed at release of the hostility and help in understanding their feelings and accepting them so that the guilt is allayed.

The social worker's role in the setting here is to give suggestions to parents and to school that concern the relief of pressure and later to assist the parent in understanding her relationship to the child in the light of her own drives.

FEARS IN RELATION TO SCHOOL ATTENDANCE: A STUDY OF TRUANCY.*

By Irma Mohr, *Chief School Social Worker,* Bureau of Child Guidance

Board of Education, New York City

Sharply differentiated from the neurotic syndrome known as school phobia is the truancy syndrome, based on fears both real and neurotic, springing from deprivation so severe and aggression so primitive that the child feels driven not only to evade the school but to evade his parents as well. The truant has been legally defined as the child who is absent from school without the knowledge of his parents. Frequently, he leaves home for school but fails to arrive, or during the school session he secretly leaves the building not to return home, but to wander aimlessly alone or with other truants who share his fear and anger toward adults.

In school phobia we find the neurotic child taking flight from his own aggression which he has projected upon the teacher. Truancy, on the other hand, is usually not touched off until the child has experienced a real loss of security, a real defeat or frustration in the school setting. The fear and anxiety which cause him to escape are not as dramatic nor as paralyzing as the fears in school phobia and since truancy represents a turning away from both home and school, the aggressive, hostile elements are immediately more clear. The truant, therefore, invites the very rejection he is seeking to escape and we recognize less readily the suffering which provoked his withdrawal. The truant has seldom experienced enough real relationship with his parents to manifest the anxious clinging to the mother so characteristic of school phobia; rather he hides his hurt, running away like the very young child in fear of the parent and in the same primitive manner maintaining complete denial of his absence to the parent.

A certain amount of casual truancy, particularly at adolescence, may be related to cultural patterns or to boyish pranks characteristic of the age group. We are concerned here with the kind of persistent truancy which has resulted in referral to a child guidance clinic. Although the number of truants in the New York City schools far exceeds the number of children suffering from school phobia, the proportion of the latter group treated at the Bureau of Child Guidance exceeds the former. The child with symptoms of school phobia has come to be recognized by school personnel as a sick child, in need of skilled help. The factor

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of unlawful absence still overbalances the factor of maladjustment in the case of the truant so that the latter is referred to the Bureau of Attendance for notification of the parents and return to school. It is only when the child fails to respond to routine follow-up over a long period, or when the school recognizes marked learning, emotional or behavior problems that he is referred for clinical study. Yet in truancy as in school phobia the timing in treatment is important; the child must be reached before he has experienced so much rejection and defeat that all of his hatred is focussed upon the school.

This paper is based upon a review of forty cases known to the Bureau of Child Guidance of New York City, including thirty-six boys and four girls. All of the cases analyzed had complete diagnostic study and were seen by the social worker, the psychologist and the psychiatrist. Fourteen were carried in treatment by the Bureau, and thirteen were treated by a case work division of the Bureau of Attendance or by family case work agencies in cooperation with the Bureau. For the remaining thirteen, either placement or exemption from school was recommended and effected.

Analysis of the parent-child relationship among the group studied reveals a consistent lack of support from the parents in building in feelings of adequacy and self-acceptance, further aggravated by a history of frequent moving about, with many changes of schools. Either the father or the mother was described as a punitive person and frequently both used physical punishment upon the child. The majority of the parents came from a low economic level with little educational drive either for themselves or for their children. Several parents had played truant themselves in childhood; several fathers had criminal records; several were alcoholic and were diagnosed by the psychiatrist as latent homosexuals. Seventeen children came from homes broken by the death, desertion, divorce or illness of father or mother. In fifteen other homes the parents revealed constant marital friction. Other mothers complained of their husbands' poor work adjustment; in only two instances however, were both parents working outside of the home. Among the majority, the boys lacked opportunity for masculine identification and particularly among the adolescents they were subjected either to aggressive, driving mothers or to punitive fathers who resented their efforts toward masculine independence.

Because of their own feelings of inferiority, the parents were frequently evasive and protective with the social worker. Although their pattern was often to project blame upon the school for the child's

truancy, further contact revealed their feeling that the child was bad and that his behavior was a reflection upon their own competence. Because they were often so hurt themselves it was only rarely that they sought help for the child's difficulties and actually needed a great deal of reassurance before they could trust and confide in the clinic worker.

When seen by the psychologist, twenty-three of the children studied tested within the normal range of intelligence. Five adolescents, diagnosed as neurotic, were of superior intelligence. Nine fell within the dull normal range and three were of borderline intelligence. Where a Rorschach test had been administered to those within the dull normal group, the findings usually indicated that the child had greater intellectual capacity than he was able to demonstrate. These findings would suggest the fallacy of the common assumption that the majority of truants are of dull-normal intelligence; it would appear instead that they tend to function at this level because of their defeatist attitude.

Achievement tests revealed one non-reader, a boy of eight, and eight other boys from nine to sixteen were very seriously retarded in reading. All of this group had poor relationships with their mothers and had apparently never been able to move into satisfactory school relationships. A larger number (fifteen) were seriously retarded in arithmetic, suggesting that they had never achieved sufficient identification with authority to subject themselves to the drill and routine required for mastery of this subject.

Indicative of their feelings toward themselves or of their neglect in the home was the dirty, unkempt appearance which these children presented when they came to the clinic. Among a few of the neurotic adolescents only, was any interest in personal appearance noted. With the psychiatrist they invariably expressed marked feelings of being unloved. They tended to show a defeatist attitude, a fear of life, a lack of courage, identified by Alexander with traumatic feeding difficulties. Developmental histories, when obtainable, bore out this supposition. One is impressed with the amount of stuttering or stammering among the neurotic, with the lisping or blurring of speech among the other groups. Nail biting was frequently noted as well as some finger sucking. All were tense and fearful, related only superficially in the first contact and confessed feelings of inadequacy, failure and futility. One fourteen year old boy, for instance, remarked: "I wanted to be an aviator, but you got to go to a lot of trouble."

Among the nine who had received Rorschach examinations the latter revealed a consistent pattern of introversion, evasion, running away,

suspicion and withdrawal. All had an active phantasy life, some showed obsessional or schizoid trends. In addition to resistance and unexpressed hostility there was frequently noted the child's confusion about his identification, whether masculine or feminine.

With the psychiatrist, the majority (twenty-three) were diagnosed as primary behavior disorder, frequently with neurotic traits; fourteen adolescents were classified as anxiety or obsessional neurosis and three adolescents were found to be schizophrenic. The high ratio of the latter may be explained on the basis that truancy frequently occurs in adolescent schizophrenia. It has been pointed out moreover by Klein that some of these adolescents may show marked withdrawal to be distinguished from true schizophrenia, in their ability to respond to relationship.

The psychiatrists' findings clarify that either these children had not moved beyond an infantile level of development, or that the regression which accompanied their withdrawal from school was often so severe as to block them in achieving any satisfactory sublimations. The question may be raised as to why this type of behavior seems to occur so much frequently among boys than among girls. Other studies likewise have revealed that truancy, like reading disability, is far more common among boys than among girls. The explanation has been offered that in their psycho-sexual growth boys develop more aggression than girls as a defense against castration fear and therefore, have more difficulty in sublimating through learning activity. Truancy among girls seldom occurs until adolescence and is then related to an upsurge of aggression toward their parents who give them little support as they struggle with the conflicts of puberty.

Among the four boys studied during their latency period (six to ten) we find all in the pre-school stage of emotional development. For these children there was no latency period, since they had not had enough relationship with their parents either to move into or to resolve the oedipal situation. They transferred their feelings of being unloved from the home to the school and required unusual warmth and understanding from the teacher to move out of their protective shell. With the exception of one six year old, whose truancy was a repetition of his earlier running away from home, truancy for this group started in the second or third grade, at the point where their anxiety due to primitive fears increased as they experienced defeat in relation to their classmates and sometimes sensed the teacher's rejection because of their inability to learn.

Typical of the severity of disturbance among some of the children with reading disabilities was Edward, an eight year old boy, whose truancy started when he was required to repeat the second grade after having repeated the first. He often wandered over the city and remained away from home until late at night. Edward was the seventh of nine children, small for his age and undernourished. His father had served a prison sentence for burglary and was known to be alcoholic. He boasted of his truancy as a boy, yet beat Edward severely and regarded his referral to the clinic by the Bureau of Attendance as proof that he was bad. Edward's mother was cold, hostile and suspicious and out of her guilt took the boy's part in projecting all of the difficulty upon the school.

Although Edward tested within the dull-normal range, his Rorschach indicated potentiality for better achievement. After three years in school this child was still completely unable to read, although he was up to his grade in arithmetic.

With the psychiatrist Edward was extremely infantile and tense, yet related sufficiently to reveal his abject despair:

"My teacher don't like me and I don't like her . . . " "I don't like the work. It's hard. She always crosses it. I never get an A. I never get even one A. I always get a C." . . . "Bad marks make me feel dumb and that hurts so I don't want to go to school. I'm sure that the teacher don't like me. It makes me sad and it makes me mad."

Of his parents, he said: "I feel my mother don't like me. She tells you, she says, "I don't like you . . . But I have other friends." He felt that his father also liked him least. "I stay out of the house. It's better to stay out of the house; then you don't get a beating."

This boy confessed to frequent fears that someone would kidnap his mother and throw her in the East River. He frequently stole pennies from her to buy candy since the only way he could get pennies was to steal them.

Within the classroom Edward's teacher said of him: "He is no bother, he just sits." It is characteristic of these children not to show overt aggression in school until adolescence: they may, therefore, not be referred for help as readily as the child whose hostility is more openly expressed.

If timing is important in the treatment of truancy, it is apparent that children like Edward should be reached during the pre-school period. We see Edward driven to repeat the pattern of an inadequate father and see his whole relationship with adults based upon evasion and sly

furtiveness because he has never learned to trust any adult. Under tutoring therapy Edward did show a beginning capacity for relationship, yet because his family could not take responsibility for bringing him regularly, this had to be discontinued. Although school remained a frustrating experience in terms of achievement, Edward's attendance did improve as he was transferred to a small opportunity group. His most meaningful relationship was with a boy's worker in a settlement house near his home and here he found his most satisfying experience.

The trend toward nursery and pre-kindergarten classes in our public schools enables us to reach children like Edward and to nurture their capacity for love provided our personnel is capable of real mothering, and provided our groups are kept small in size. Another trend toward an all day program in the schools which meets the need of all children for expression through creative play activities, again in small groups, enables them to find in the school experience the focus of their security rather than the focus of their hatred. The current practice in the primary grades of having the teacher promoted with her class for two or three years, affords opportunity to these love-starved children for identification with a mother person. We cannot emphasize too strongly the emotional climate of the school as a factor in having the child maintain a sense of belonging nor the consistent understanding of the teacher as a therapeutic experience which may help the child move into growth. One role of the school social worker and of the clinic is to understand and interpret the needs of these children to the school personnel, to further the identification of the parents with the school as a place where they too will be accepted and understood and so to create a prophylactic environment for the child within the school setting.

In contrast to these infantile children, unready for learning, is another group whose initial adjustment to school seems more satisfactory. Five, when referred at the age of eleven or twelve, were up to grade or above grade in reading, although a year or more retarded in arithmetic. Their truancy during the latency period was relatively minor, but increased markedly as they entered the pre-pubertal period, when their aggressive impulses were intensified. These children, like the others, felt strong resentment toward their parents and turned their back upon the school when a similar resentment was touched off there. Unlike the children with reading disabilities, they were more ready for relationship, and responded gradually to the interest of the social worker, the consistent warmth of the teacher, as well as to a developing understanding on the part of their parents.

Tom, an eleven year old boy in the fifth grade, the oldest of six, tearfully confessed that his mother did not love him as much as the others and told of frequent quarrels between the parents. He felt that he "got more lickings" from both parents than the other children. He knew that he was "bad" at home. He was criticized because he stayed out until late at night. He admitted to stealing from his mother and to telling lies in order to avoid punishment. He also stole fruit from the pushcarts and toys from the five and ten. He recalled that his truancy had not started until the principal insisted that he must go to the dentist although he was afraid. He continued to play "hookey" because he felt that "the teacher did not treat him right." With the psychiatrist he told of disturbed sleep and of bad dreams in which he saw himself dead. In the classroom, Tom sat passively day dreaming or withdrew from the group activities to read fairy tales. He had been left back twice and was now repeating the fifth grade.

Treatment here was wholly successful not only in placing Tom in regular attendance but in helping him to become a more active participant in classroom activities and to find constructive outlets through a boys' club. Special grants from the Department of Welfare for extra food for this undernourished boy served the double purpose of encouraging his physical development and of giving him some added attention in the home. His mother, the victim of a deprived childhood herself, responded to the contacts of the attendance worker and the teacher and became less punitive and more reassuring toward the boy, with the result that the stealing, as a demand for love from the mother, subsided. The warmth and sympathy of the teacher, in patiently working to give this child a sense of belonging, helped him to become increasingly positive about school. Contacts with Tom, his parents and teachers were continued over several years until we were assured that he was able to go forward alone.

Among the thirty-one children referred for truancy during their adolescence, we find a somewhat wider range of family patterns, of economic status, of intellectual equipment and of personality deviations. It is unfortunate that the child has to make the change into the departmental system of the seventh and eighth grades, into Junior High School or into Senior High School at the time when his ego strength is at lowest ebb because of intensified sex conflicts. The transfer into a departmental system or into a school farther from home, where the child feels lost in a strange and impersonal atmosphere often arouses more fear and insecurity than he can handle alone.

Among this group only five had been truant prior to adolescence; the majority had found some satisfaction in their work and in school relationships until they moved into a new phase of growth and into new school adjustments. All approached adolescence with strong dependency needs due to thwarting in their early growth. Some seemed to have found the support which they lacked at home within the school setting and felt overwhelmed when they lost this feeling of at-homeness in a new school. Among those who fall into the category of primary behavior disorder, their frequent retardation in reading and arithmetic gave them a greater sense of defeat as they sought to transfer from one teacher to a series of teachers in a new setting. Being left back at this age became particularly traumatic and left them overwhelmed with feelings of inadequacy. Their parents had frequently become more openly rejecting in response to their adolescent rebellion. Their teachers found it difficult to arouse interest in a remedial program. The fear of revealing their adolescent inadequacies, which started their truancy, had now given way to secondary gains. It is important to note that many came from delinquency areas where truancy is accepted as a cultural pattern among boys and youth so that the latter gained a certain security and recognition in adopting this form of protest against parental and school authority. Other secondary gains usually followed through gang activities, sex delinquency, trips to the movies, but through all of this, the truant was seldom free from fear.

The guilt of the neurotic child over awakening sexual urges, over homosexual conflicts, his resentment toward his hostile, yet controlling parents and his fear of retaliation were all intensified as he experienced confusion and loss of identity in a new setting. With the neurotics, truancy may become a means of blocking off their sex conflict; in denying their truancy they deny other conflicts; by defeating themselves through failure and by incurring censure from both school and parents they may take care of their unconscious guilt.

Treatment of truancy in adolescence presents a particular challenge because it becomes increasingly difficult to help these young people find satisfactions in achievement after they have fallen behind and have lost hope of school success. They soon discover that truancy may be used as a weapon in expressing hostility against the parent, though only negatively by running away. If treatment is arranged for them they may play truant from the therapist just as they play truant from school. Yet invariably they have capacity for relationship and if a strong and consistent support is offered they will move into a deep attachment

which may be used to stabilize them until they are able to find satisfactions in their reality. Whether they suffer from a primitive, pre-oedipal super-ego or from a severe super-ego of the oedipal period, Hacker and Geleerd have pointed out that both are inoperative at adolescence when id impulses are usually in the ascendency and the youths, with their weak hold on reality, are really looking for controls.

Where there is a division of function between the Bureau of Child Guidance and the Bureau of Attendance as in New York City, it has been found important to have the attendance worker take responsibility for follow up of absences, even though the clinic may be active in treatment. It is recognized today that case work skills are essential in both settings. The clinic worker participates with the attendance worker in furthering the latter's understanding of the truant's conflict so that he may be both warm and firm in facing him with the reality of school attendance. With some of the neurotics, whose anxiety is very much increased in the group situation, a period of medical suspension may be necessary and for the schizophrenics, who are too confused to function, suspension is always recommended. With the latter it is important to check their regression by maintaining some regular contact in order to help them toward satisfying activities. One adolescent girl diagnosed as schizophrenic, kept every appointment at the clinic, and one day came in spite of a driving rain to see the worker.

Our work with both parents and children of the truant group calls for agency initiated contacts on the part of both the attendance worker and the clinic worker. Because they have so many times been hurt by adults, it is only through our activity in reaching out to them and in maintaining a close contact that they are convinced that we care. It is important that the worker assure the child that she *wants* to see him, since if choice is offered as to whether he wants to come, he may interpret the worker's attitude as indifference or rejection.

Timing is again of the utmost importance in establishing a helpful relationship with the adolescent truant, while he is still in the early stages of his fear and sense of defeat, and before he has found secondary gains through identification with delinquent patterns or through a neurotic cycle of fear, hate, guilt and punishment. To this end the assignment of a counsellor within the school to screen children in difficulty and to call on the school social worker or the attendance worker may result in our reaching the child before he has built up his defenses.

With the parents it often becomes necessary to relax their primitive feeling of their own badness which they project upon the child. Be-

cause of their own deprivation, hostility and dependency need, they too are not always ready to reach out for help, yet may respond to a supportive relationship if we offer them concrete evidence of our interest and show a willingness to contact them in the home until they are sufficiently reassured to visit us in the school. Interceding with the Department of Welfare to obtain special grants where there is malnutrition, helping them to obtain much needed medical care, and clothing, providing opportunities for recreation, have all been helpful in reassuring them that our concern is for them, not against them.

The presence of both a teacher counsellor and a social worker in the school were strategic factors in reaching Alice, a girl of fifteen, whose truancy started upon her entrance to high school. A passive, dependent and compliant child, deprived of love by both parents, she had always gained recognition through her conformity rather than through her achievement. When this adjustment broke down in a more impersonal setting, she escaped with a boy in her class with whom she had sex experience. Then followed recurring episodes of running away from both home and school in order to relieve her guilt over these clandestine experiences. Alice invariably went to the homes of friends, looking for more love and understanding than she received in her own home. She was also seeking to escape from an infantile attachment to her father, who covered his favoritism for this pretty adolescent daughter by being unusually stern with her.

After Alice was able to talk through her concern with the psychiatrist, who played a father role with her, after the parents were helped toward greater understanding of Alice's adolescent needs and after the teacher counsellor and the social worker in the school took a warm and consistent interest in the girl, and provided her with a simplified program related to her abilities and interests, all truancy and running away ceased. Alice transferred her attachments and identifications to boys and girls in regular attendance and was very anxious that they not learn of her former delinquencies.

It has been noted that nearly one third of the group whose truancy occurred at adolescence required either exemption or commitment for treatment of their difficulty. The recommendation of commitment is usually related to the adolescent's need for a support and a control which he is unable to find in his own home. The hostility he encounters from his own parents may block him in the incorporation of any authority until he is removed to the more neutral environment of an institution which meets his unsatisfied dependency needs at the same

time that it affords him opportunity to test reality and to develop ego strength.

We have recognized that truancy may have different meanings at different age levels. At all age levels, we find it the pattern of expression of a passive, dependent child, whose deprivations, frequently both cultural and emotional, have left him fearful and hostile. Usually too fearful to express his aggression in more overt ways, he escapes from an unhappy school situation which has touched off a hurt earlier experienced in the home. Successful treatment of truancy therefore requires the creation within the school of a prophylactic environment in which there is less possibility that the child may have his feelings of rejection reactivated. Although the early relationships of this group with the social worker and the clinic may be tenuous, all want and use relationship, provided the worker is active in moving out to them and in offering strength and consistency in a supportive relationship. Because of their deep-seated and unsatisfied dependency needs, these children, at adolescence, still look for and need control. In running away from school they may be running away from their own sex impulses as well as seeking the end of the rainbow. At all ages, the truant adjusts best among the warm, personal relationships of a small school setting, where he can achieve a feeling of at-homeness. As we have moved from a legal to a diagnostic approach to truancy, the school social worker has begun to meet the challenge of this group, and to recognize the values in helping through agency-initiated contacts.

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DISCUSSION OF THE PAPERS ON "CHILDREN'S FEARS" AND "TRUANCY"*

By Rose Green, *Associate Professor of Social Work,*
University of Southern California, Los Angeles, California

Before discussing these papers I would like to express appreciation of the thoughtful work that has gone into writing them, but more importantly, to express an appreciation of the work that these papers reflect. Written out of the experience of a psychiatrist and psychiatric social worker, the two papers present a common base in thinking and in point of view about problems of children. The papers also present a helpful picture of collaborative work and differing responsibilities of psychiatrist, and social worker, teacher, and attendance worker.

The content of the papers has one focus: the child who does not get to school. This is the child for whom the function of the school—teaching—and learning—cannot be carried on. Although these papers have presented some essential differences, and a wealth of variables which are important in the technical skill of dealing with these children, the emphasis on one basic similarity cannot be overlooked: the emotional factors in the problem of not getting to school. It is easy to sense emotional factors in a child's fear of going to school—easy to be sympathetic to the possibility that the child is in some conflict or trouble. It is not as easy to sense emotional factors in a child's truancy —not easy to be sympathetic to the possibility that the child is in some kind of conflict when he often expresses a willful I-don't-care attitude. Our natural reactions to this different sense of problem in the child can have much to do with our clarity and objectivity.

Picking up the similar focus on emotional factors, it is an accepted hypothesis in psychology that a child's emotional stability has much to do with his relationships with his parents. In nearly all of the thirty-two cases of the fearful children, the mothers were over-anxious, solicitous, domineering women, and the fathers gentle, kindly, and accepting of the domination of their wives. In only eight cases, of the thirty-two was there open friction between parents—with separation imminent in but two (two out of thirty-two, when our present divorce rate is three out of five). Much as one may see trouble in this description of patterns of behavior in the parents, I would like to call your attention to the idea that the thirty-two families of the fearful children

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presented, on the whole, at least one parent who was able or willing to *be* a parent.

On the other hand, in the study of the forty truant children, seventeen came from homes broken by death, desertion, divorce, or illness; and in fifteen other homes, parents revealed constant marital friction: 17+15=32, out of 40, broken or seriously disturbed parental relationships. These factors would mean consistent lack of support from parents. I would like to call your attention to the idea that in three-fourths of the families of the truant children, there were parents who were unable or unwilling to *be* parents.

Although the symptom of "not getting to school" is the same, we can learn much from the study of the home to help in understanding the individual child and to help in treatment of the situation. In one of these patterns of parental background, we see at least one parent anxious and wanting the child in school, and very mindful of his responsibility. In the other pattern of parental background, we see parents who, as Miss Mohr says, are so busy with their own problems that they have little time nor place for the child—parents who are not carrying much of a parental role.

These facts of family background are gathered in small numbers, but I think they would be borne out in larger studies. What is the significance of these facts for clinical treatment? for social casework's contribution in a clinic? in an Attendance Bureau?

I think it might be helpful to stop at this point to attempt to distinguish between different kinds of help implied in the above questions. Psychotherapy, help to an individual with his emotional problems, is predicated upon some capacity to form and use relationships. Of the thirty-two fearful children—coming from parents that clung together, albeit one was very anxious and domineering—twenty-eight did use psychiatric treatment and became able to return to school. Of the forty truanting children living with the broken and conflicted parental relationships, only fourteen were able to be sustained in clinical psychiatric treatment. The fourteen who continued in treatment, more than one-third of the group, is to me a remarkable number. The Bureau of Child Guidance is to be congratulated, and its work indicates the need for all of us to refine more skills where clinical treatment is part of a school system. Psychotherapy for a child has an optimistic prognosis when there are parents who are carrying parental responsibility.

Defining another way of helping implied in the above questions—social casework help occurs through the medium of relationships with

child and parent—but it *rests upon* the skillful use of realities inherent in the situation: responsibility vested in parents in our culture, the law, resources like special classes, or financial grants, placement of a child away from home, etc. These realities, inherent in each situation, make a different frame of reference for social casework with a child, or a parent, or both—than the frame of reference for psychotherapy.

I regret that I cannot share Miss Mohr's optimism that the trend to nursery classes in public schools will enable the school to reach the child and to nurture his capacity for love. Miss Mohr has two provisos to this plan as meeting the needs of the unloved or neglected child; *provided* school personnel is capable of real mothering, and *provided* the groups are kept small. I question the reality for the teacher and for the child of developing such an objective as "mothering." This does not mean that a teacher should not be kind, gentle, warm, and understanding. Teaching is a different thing from mothering. Much as we—teachers and social workers alike—may ache to give a child something he does not have, it is essential that we recognize lacks as lacks. A teacher may give a child some lunch, even lunch every day. Certainly she does it for the child, but also partly for herself as she cannot bear to see him empty-handed when she and the other children eat. But the teacher does not assume the responsibility for three meals a day, every day of the year.

In the papers of Dr. Thompson and Miss Mohr, the social casework activity is more clearly seen in relation to school personnel than with the child or parent—helping a mother let her child go to the school psychiatrist, arranging for a mother to sit in a class, helping to interpret the needs of a child to a teacher, etc. This needs to be done, and is very important.

Just as we need to see objectively the child's needs and troubles, so also we need to see the parent's needs and troubles in relation to the specific situation with his child. A social worker needs to be aware that when she asks a parent of a fearful child to bring him regularly to clinic, she is usually offering that parent a way to help discharge a strong sense of responsibility. The parent is usually relieved and grateful that he can now do something about a situation which actively worried him. A social worker also needs to be aware that when she asks a parent of a truanting child to bring him regularly to clinic, the worker is asking an extra responsibility of a parent who is not fulfilling the ordinary responsibilities of his role.

In these two papers, casework activity is not clearly portrayed with

the parents. This is the problem of our whole profession, not that of any single agency or social worker. The following are quotations from the papers. " . . . to avoid any semblance of pressure, and yet get the family to ease pressure on a child"; " . . . his family could not take responsibility for bringing him regularly." This area of work with parents needs further clarification and concrete specificity and must grow out of understanding of a parent's necessity or inability to do certain things with and about his child. It seems to me that one of the functions of the school social worker is to further the identification of the parents with the school. This is a most difficult job in "problem situations," and it would be interesting to see further study analysing "how" it might be done.

The present papers point to the need to explore and develop further skill in the area of work with parents, of how to work with the parent in the role of parent, with the focus on the parent-child relationship within the framework of the social realities of our public schools.